# Patient-Centered Care: Past, Present, & Future

# History

- Nelson & Batalden:  Value Compass
  - Building on Deming & Donabedian
- Von Korff & Wagner
  - Incorporating Social & Learning Theory
- Wasson – HowsYourHealth.com
  - Tools for an information Age
- IOM “Quality Chasm” – Ideals for the future

# Patient-Centered Care

- As opposed to what . . .
- Is the health system organized around the needs of patients?  If not, whose?
- What drives health care:  Patient Need, Quality or Cost?
- Who drives the decision-making?
- When you seek health care, what do you expect?

# Toward a More Productive Interaction Between a Patient & Health Care System . . .

Contributions of:

- Paul Batalden, MD
- Eugene Nelson, DSc, MPH

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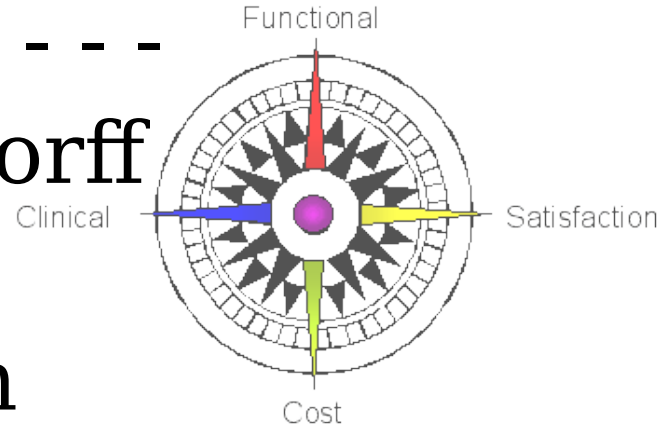
- Michael Von Korff
- Ed Wagner
- John Wasson



# to Patient-Centered Care

. . .

- What lies beneath a productive interaction?
- Theoretical Background
  - Donabedian’s model of quality health care.
  - Linkage of understanding of clinical processes & balanced outcome measures
  - Importance of the patient’s perspective.
- Adaptation of Deming’s model of system to health care.
  - Deeper insight into levels of health care systems.
- Continual improvement and domains of knowledge.

# Donabedian . . .
# (Example: Wait Time in ER)

- Structure →
  - Number of Beds
  - Number of Doctors
  - Number of Nurses
- Process →
  - Triage Protocol
  - Call Schedule
  - Staffing Rules
- Outcome
  - Wait Time
  - Patients who leave
  - Worse Medical Condition

# What are “Assumptions” of Health Care?

- The aim of health care is to prevent or diagnose and treat disease and thereby reduce or limit the burden of illness by restoring or maintaining healthy functioning.
- Human functioning is made up of biological, physical, mental and social health.
- High quality health care provides the services (that is, clinical care processes) that are most likely to achieve the health outcomes desired by the patient.
- The value of health care is a function of quality, costs, and volume.

Nelson, Mohr, Batalden, 1996

# Batalden & Nelson

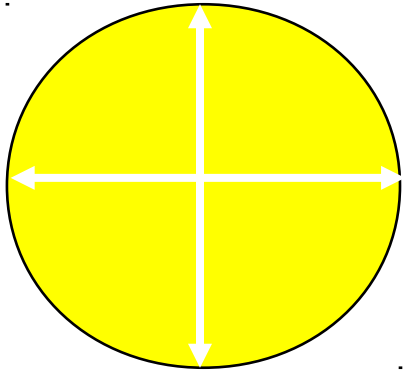
- Change in traditional concept of health care outcome(s)
- Improvement shouldn’t be “add-on,” but be built into health care delivery
- Change Paradigm:  From Cost to Value
  - ?  Is there a difference?  If so, what?

# The Clinical Value Compass

- Physical
- Mental
- Social/Role
- Risk Status
- Perceived Well-being

**Functional Status & Quality of Life**

$$\text{Value} = \frac{\text{Quality}}{\text{Costs}}$$



**Biological Status**

- Mortality
- Morbidity
- Lab tests

**Satisfaction Against Need**

- Health Care Delivery
- Perceived Health Benefit

**Costs**

- Direct Medical
- Indirect Social

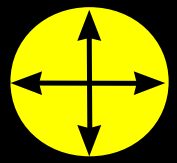
*Developed the concept of balanced outcome measur*
*from the patient's perspective. Like the compass ros*
*Inherent hierarchy of points . . .*

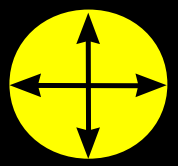
# Batalden & Nelson Basic Framework

CASE MIX

PROCESS

OUTCOMES

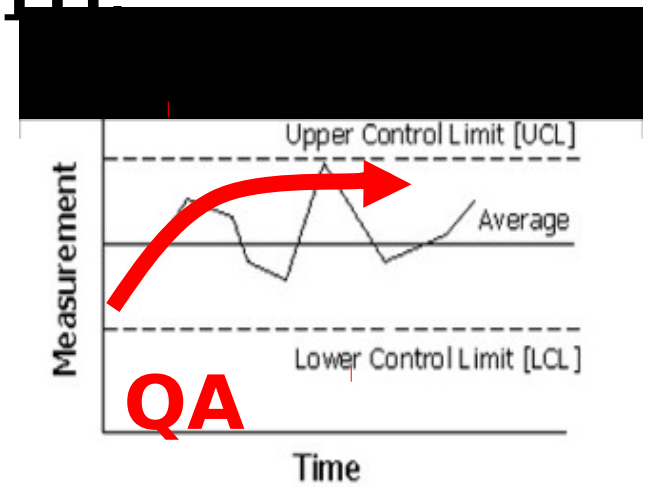


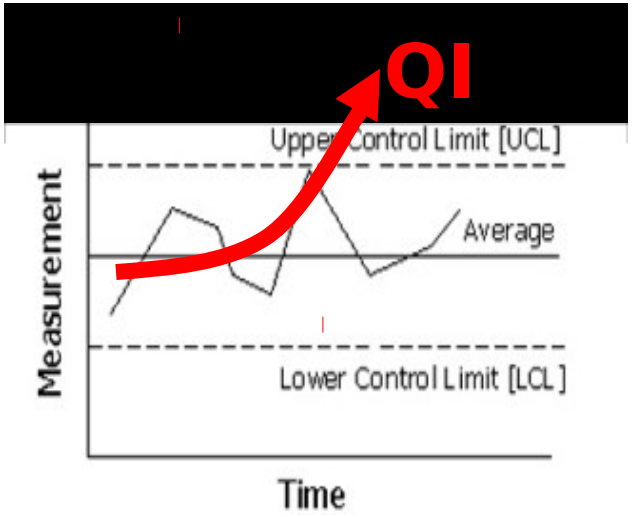


- Value = Quality ÷ Costs
- Episodes = Longitudinal Care
- Outcomes = Really Transitions

# Lessons from Production Management

- Deming & Juran: *Quality Cannot be Inspected into a Process* (*or Product*)
- Upper: *Quality Assurance* will support best outcome <u>within</u> system design
- Lower: *Quality Improvement* will <u>transcend</u> design specifications *(limitations)*



# Knowledge Domains for the Improvement of Health Care

1. Health care as process, system.
2. Variation and measurement.
3. Customer / Beneficiary knowledge.
4. Leading, following and making changes in health care.
5. Collaboration.
6. Social context & accountability.
7. Developing new locally useful knowledge.
8. Professional subject matter.

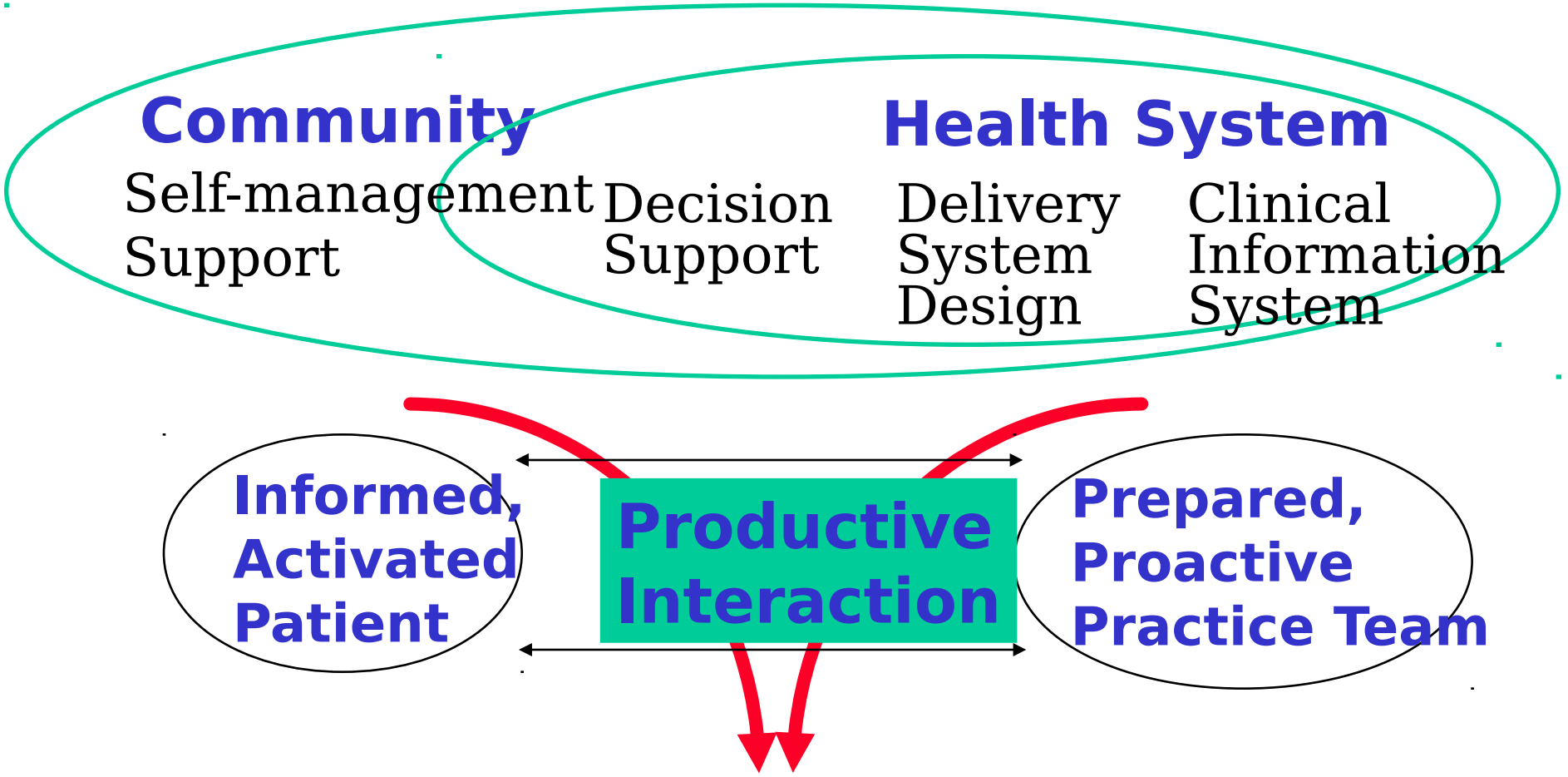
# Collaborative Management of Chronic Illness

- Demographics: Chronic Illness affects approx. half US population, accounts for ¾ costs (Von Korff, Wagner)
- Patients & Families Primary Caregivers
  - Often Inadequately Informed
  - Often Viewed as “competing” with medical care
  - Patients perspective on problems may be radically different than “providers”
  - Lost Opportunity for achieving optimal outcomes

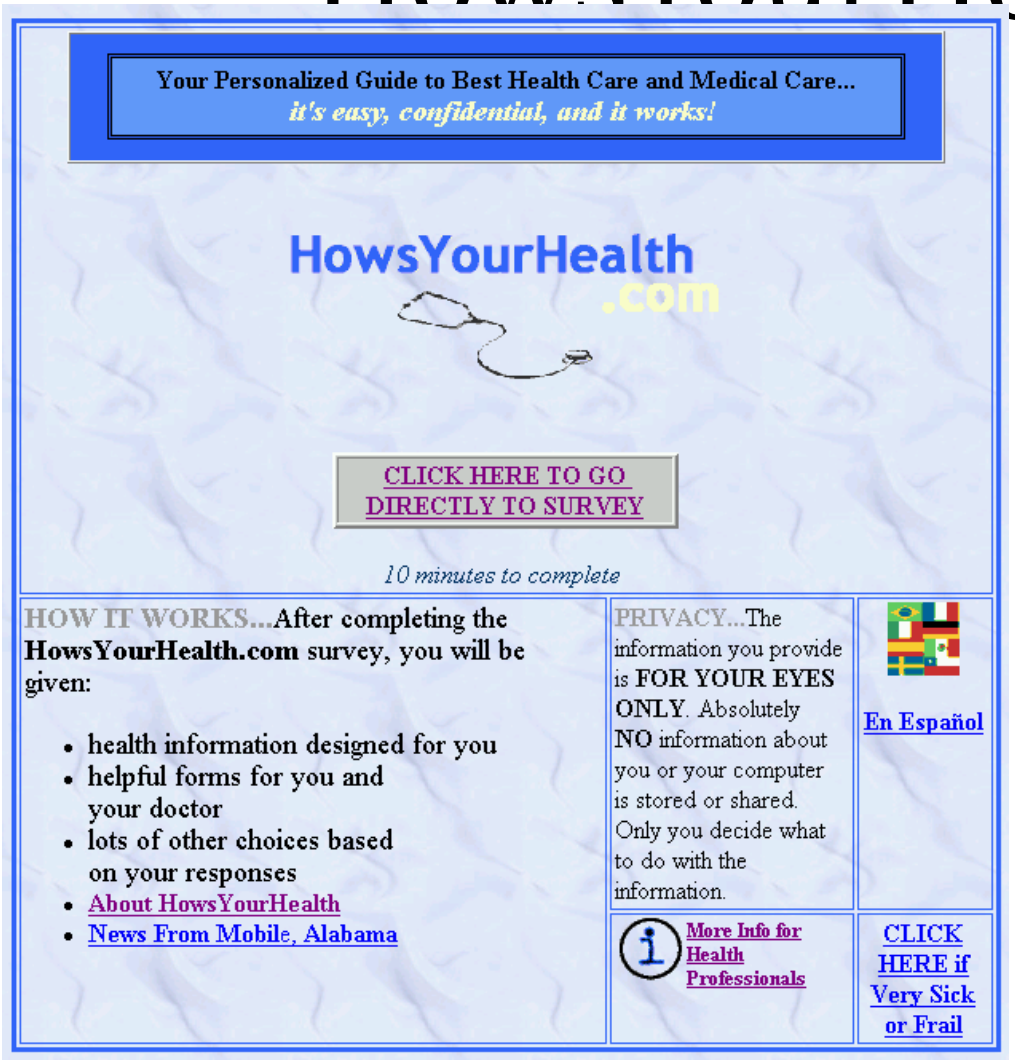
# Collaborative Management of Chronic Illness

- Collaborative Definition of Problem & Outcomes
  - E.G. For diabetic, may not be HgB A1c<7, but prevention of impotence
- Approaches to Care Based on Theories of Learning & Motivation
  - E.G. Smoking Cessation – Assessment of "Readiness to Change" (Motivational Interviewing, Trans-Theoretical Model of Change) vs. simple advice to stop or direction to particular type of program
    - Anorexia, weight loss, diabetes, congestive heart failure . . .
- Not the traditional approach . . .

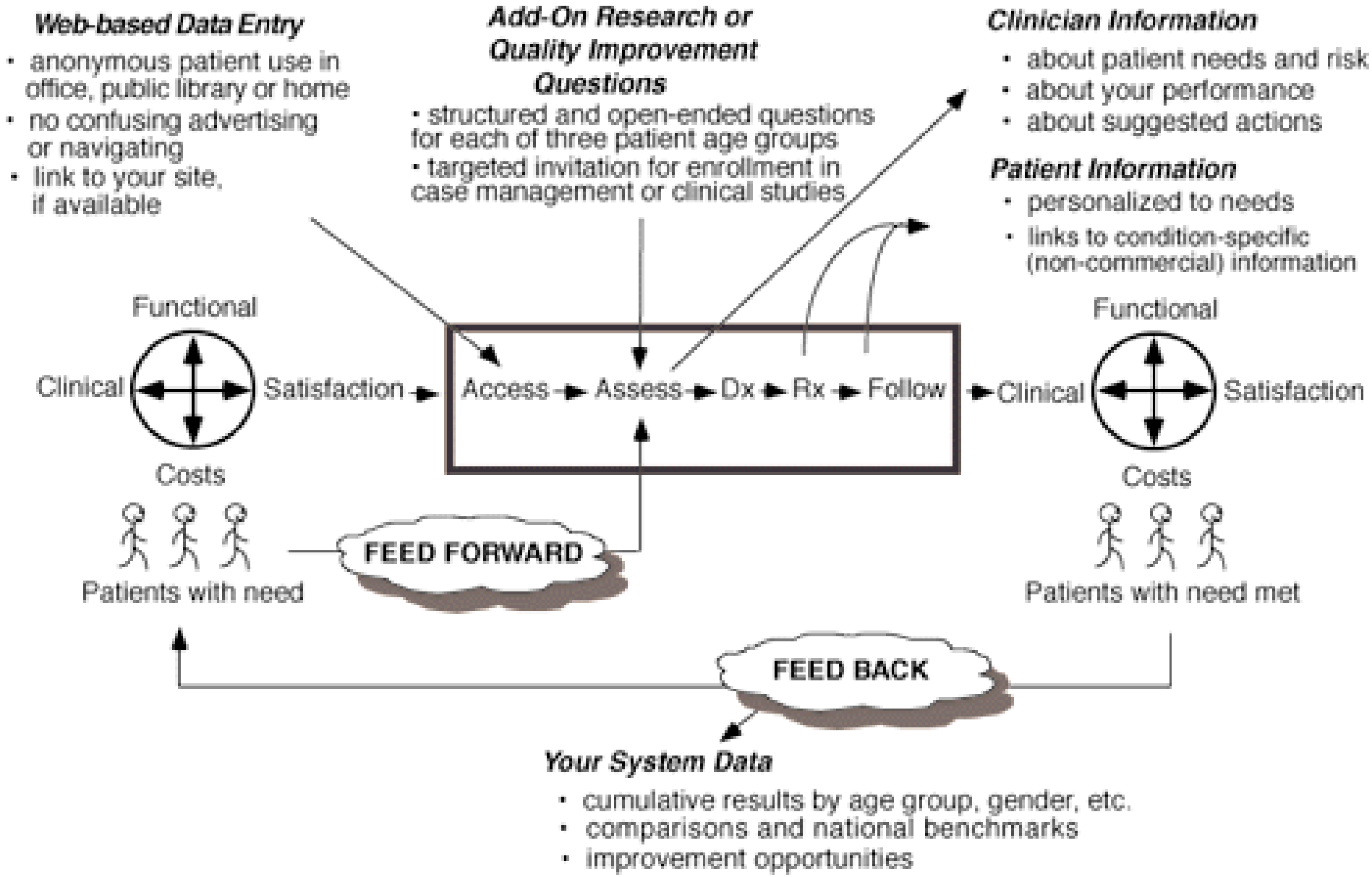
# Care


Community
Self-management Support
Health System
Decision Support
Delivery System Design
Clinical Information System
Informed, Activated Patient
Productive Interaction
Prepared, Proactive Practice Team
Functional & Clinical Outcomes

# Wasson - Applying the Model: HowsYourHealth.Com

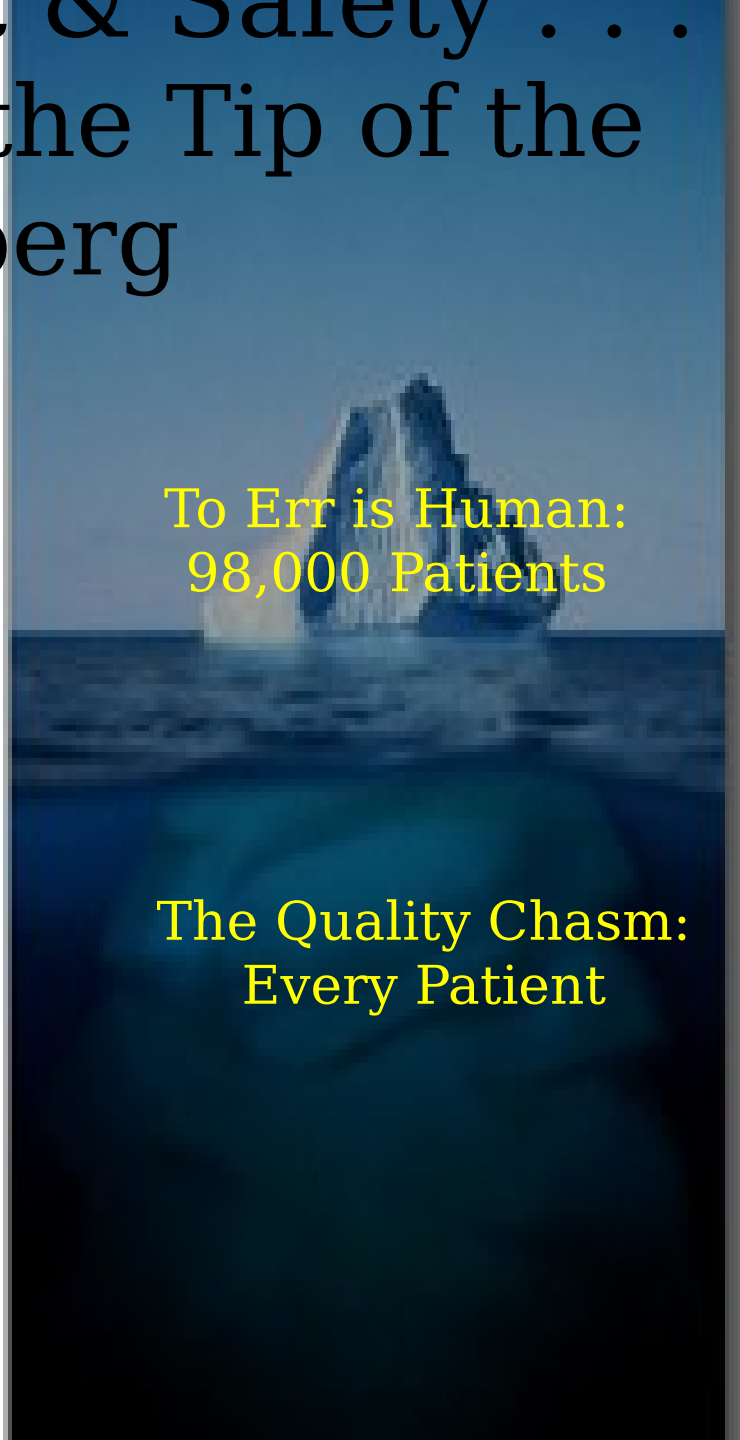

Your Personalized Guide to Best Health Care and Medical Care...
it's easy, confidential, and it works!
HowsYourHealth
.com
CLICK HERE TO GO DIRECTLY TO SURVEY
10 minutes to complete
HOW IT WORKS...After completing the HowsYourHealth.com survey, you will be given:
health information designed for you
helpful forms for you and your doctor
lots of other choices based on your responses
About HowsYourHealth
News From Mobile, Alabama
PRIVACY...The information you provide is FOR YOUR EYES ONLY. Absolutely NO information about you or your computer is stored or shared. Only you decide what to do with the information.
En Español
More Info for Health Professionals
CLICK HERE if Very Sick or Frail

# How's Your Health.Com

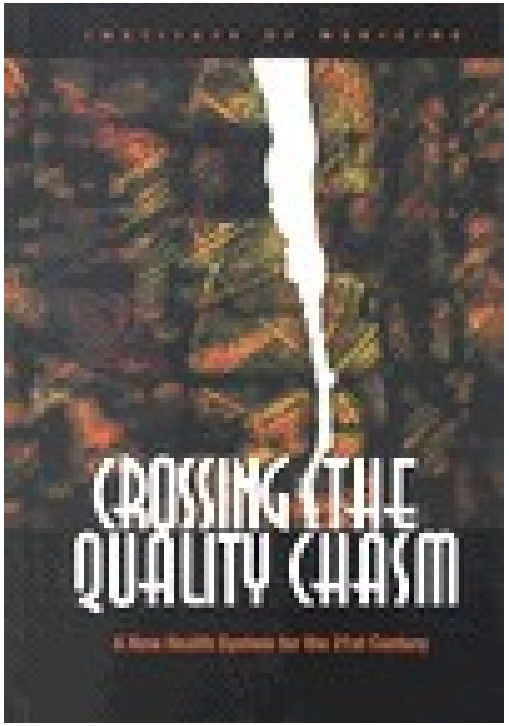


# Measurement & Safety . . . Safety: Only the Tip of the Iceberg

- Patients don’t seek healthcare just to be safe
  - Come for help maintaining & improving health, managing disease & distress
- To Close the Chasm . . .
  - The Gap between known optimum & anything less



# Toward an Ideal System



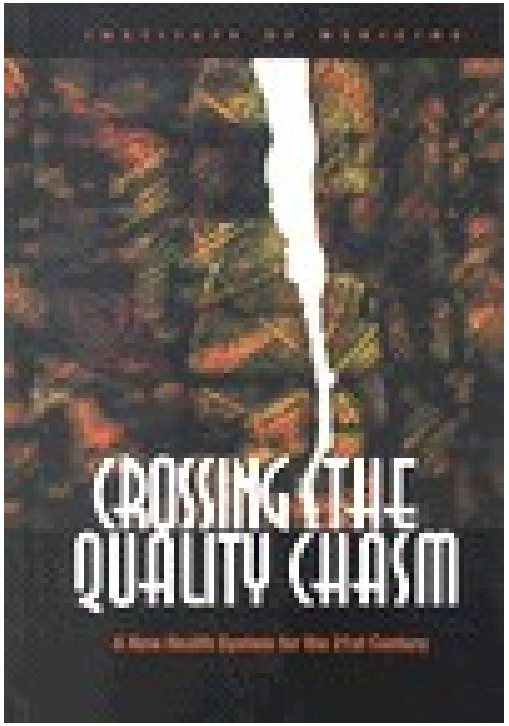

<u>6 Cardinal Characteristics (Aims)</u>:

- Safe
- Effective
- Equitable
- Efficient
- Timely
- Patient - Centered

# IOM & National Agenda

## *Crossing the Quality Chasm*

## *2001*




***Ten Simple Rules***

# Ten Rules for Health Care Reform

1. Care based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

# Ten Rules for Health Care Reform

2. Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences

# Ten Rules for Health Care Reform

3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making

# Ten Rules for Health Care Reform

4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information

( **Q:** Who owns the medical record ? ? ?)

# Ten Rules for Health Care Reform

5. Evidence-based decision making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place

# Ten Rules for Health Care Reform

6. Safety as a system property.
   Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors

# Ten Rules for Health Care Reform

7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

# Ten Rules for Health Care Reform

8. Anticipation of needs. The health system should anticipate patient needs, rather than simply reacting to events

# Ten Rules for Health Care Reform

9. Continuous decrease in waste. The health system should not waste resources or patient time

# Ten Rules for Health Care Reform

10. Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

# IOM: Health Professions Education: A Bridge to Quality (2003)

Five Core Competencies for the 21st century:

- **Provide patient-centered care**
- **Work in interdisciplinary teams**
- **Employ evidence-based practice**
- **Apply quality improvement**
- **Utilize informatics**

**Skills Needed:**

- **Ability and willingness to share power and responsibility with patients (and caregivers).**
- **Communicate in shared and open way.**
- **Deal with patients as individuals.**
- **Reach out**
- **Enhance prevention, health promotion and population health**

**Barriers identified:**

- **These are not funded activities**
- **Skill sets are not routinely taught in professional school curriculum (?why not)**
- **No consensus definitions – hence no measures or definition of ‘success’**

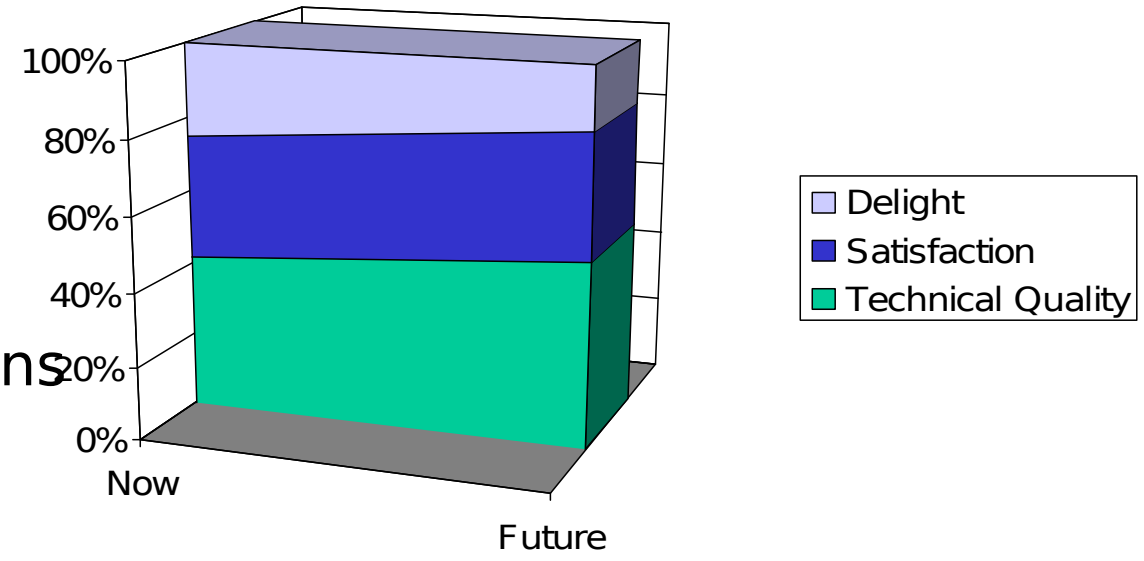
# Patient-Centric Outcomes… Goal: Exceed Expectations

Technical Quality is assumed.

Quality ≠ Satisfaction. . . It is a basic expectation!

Satisfaction =
Meeting Expectations

Delight =
Exceeding Expectations



# Quality, Satisfaction, & Delight: Japanese Cars

- 1960 - 70’s: Technically inferior, assumed quality missing (Lost Business)
- 1970 -80’s: Had desirable attribute - fuel efficiency, advanced technical quality, satisfaction

# Quality, Satisfaction, & Delight: Japanese Cars

- 1990's: Delight
  - Technical Quality Assumed / Satisfactory
  - Personalization of Quality / Adaptability
  - Delight - Unexpected
    - Your cars "health history" available at any Lexus dealer
    - Customers Greeted by Name
    - Extraordinary Service Recovery (Loaners, Roadside Assistance)

- Reality: Technical Quality of American Cars Equivalent

# Conclusion:

- Evolution from Physician-Centered to Provider-Centered
- Hard to say that Patient-Centered Care fully realized
- Ideals of Health and Freedom from Disease, Social Function Constant.
  - What next?